Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NABIL BISHARA MD
10109 MCKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name
EL PASO ISD

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-12-2810-01

MFDR Date Received

May 02, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $ $2,350.00 for this claim but were paid $800.00. The explanation given on the EOB justifying the denial states: WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT, however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32.

Therefore, please issue a payment promptly in the amount of $1.550.00 to settle this claim."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The dispute is in regards to the reimbursement of $350.00 for the impairment-rating portion of a designated doctor examination.

DWC rule 134.204 (j)(1)(D) requires the documentation to include tables, figures and worksheets to determine whether the impairment rating was calculated using the range of motion method or Diagnosis Related Estimate method.

The enclosed medical records signed by Dr. Bishara state: "The impairment rating was 0% whole person." Since the documentation did not clarify whether the impairment rating was determined by range of motion or the DRE method, no allowance was recommended. The enclosed explanation of benefits clearly informed the provider what was lacking in the documentation

In addition, the method of impairment rating calculation was not provided on reconsideration nor was this information documented in the dispute packet. Therefore, no allowance is due."

Response Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due

December 28, 2011	CPT Code 99456-W5-WP	$50.00	$50.00
	CPT Code 99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 16, 2012

   - W1A – Workers Compensation State Fee Schedule Adjustment*Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202*
   - 16 – Claim/service lacks information which is needed for adjudication

   Explanation of benefits dated February 24, 2012
   - 193G – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly. *Medical records were not submitted with reconsideration request.*

   Explanation of benefits dated March 21, 2012
   - 193 - 193G – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-WP in the amount of $950.00 for one unit, 99456-W5-WP in the amount of $800.00 for one unit and 99456-W8-RE in the amount of $600.00 for one unit. However CPT Code 99456-W8-RE is not in dispute.

   Review of the submitted DWC-32 and Designated Doctor Examination Report support that the requestor requested a Designated Doctor Examination to address Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW) issue.

   28 Texas Administrative Code §134.204 states: "(i) The following shall apply to Designated Doctor Examinations, (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, 1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   Therefore, CPT Code 99456-W5-WP is supported.

   The total Mar for CPT Code 99456-W5-WP is $350.00

   28 Texas Administrative Code §134.204 states: "(4) The following applies for billing and reimbursement of an

IR evaluation, (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form,

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used, (II) If full physical evaluation, with range of motion, is performed, (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.

CPT Code 99456-W5-WP is not supported as the Designated Doctor Examination Report does not have documented what type of method was used for the Impairment Rating (IR) exam.

Therefore, no additional reimbursement is allowed.

2. The respondent issued payment in the amount of $300.00. Based upon the documentation submitted, additional reimbursement in the amount of $50.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/4/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.